



1304 Vermillion Street, Hastings, Mn 55033  
 Ph: 800-482-3518 • Fax: 651-389-9152

**MISSISSIPPI MEDICAID  
 DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

<b>PAYER ID NUMBER</b>	<b>CKMS1</b>				
<b>ELECTRONIC REGISTRATIONS</b>  Agreements Required	<p><b>EDI Provider Agreement and Enrollment Form</b></p> <ul style="list-style-type: none"> <li>• <b>EDI Provider Enrollment Form</b> Section 2: Please complete all areas of this section Section 4: Please supply an office contact</li> <li>• <b>Authorization</b> Provider's <u>signature</u> and date</li> <li>• <b>ACS EDI Gateway Inc., Trading Partner Agreement</b> Provider's <u>signature</u>, printed name, title and date</li> </ul> <p><b>Electronic Dental Services Provider Enrollment Form</b> Please complete all requested information.</p>				
<b>SPECIAL NOTES</b>	Each <b>Pay To Provider</b> number wishing to submit claims electronically to Mississippi Medicaid must complete an enrollment packet.				
<b>SEND ORIGINAL REGISTRATION FORMS TO:</b>	<p>Electronic Dental Services          1304 Vermillion St          Hastings, MN 55033          Attn: Provider Enrollment</p> <p>Or Fax: 651-389-9152</p>				
<b>ENROLLMENT CONFIRMATION</b>	<ul style="list-style-type: none"> <li>▪ Enrollment will be coordinated between Electronic Dental Services and ACS EDI Gateway. Electronic Dental Services will notify the provider or their software vendor when you may begin sending claims.</li> </ul>				
<b>CHANGING ELECTRONIC BILLING AGENTS</b>	If the Pay To Provider currently submits claims through another Billing Agent other than Electronic Dental Services <b>each</b> Pay To Provider must re-enroll following the procedures listed above.				
<b>CONTACT PHONE NUMBERS</b>	<table border="0"> <tr> <td>Electronic Dental Services</td> <td align="right">800-482-3518</td> </tr> <tr> <td>ACS EDI Gateway, Inc.</td> <td align="right">800-884-3222</td> </tr> </table>	Electronic Dental Services	800-482-3518	ACS EDI Gateway, Inc.	800-884-3222
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## Notice of Paper Remittance Advice Cutoff Deadline 01-01-06

Below is an excerpt from a letter dated October 20, 2005 from Dr Robert Robinson, Executive Director, and Division of Medicaid for the state of Mississippi. The letter in part advised all providers as follows.

“The Division of Medicaid and ACS State Healthcare are transitioning to a paperless environment. Effective January 1, 2006, providers will no longer receive paper remittance advices. Providers who currently receive a paper remittance advice and an ASC X12N 835 electronic remittance advice will no longer receive the paper remittance advice. The ASC X12N 835 electronic remittance advice will continue to be available.

Providers will be able to accept print images of their remittance advice through the Mississippi Envision Web Portal located at <http://msmedicaid.acs-inc.com> or retrieve ASC X12N 835 remittance advice files at <http://mississippimedicaid.acs-inc.com>.

If you are a provider who receives paper remittance advices only, you may access print images of your remittance advice. Print images of remittance advices are available on the Mississippi Envision Web Portal at <http://msmedicaid.acs-inc.com>. In order to utilize this secure feature of the Mississippi Envision Web Portal, providers will have to be a registered user of the web portal. Once the site has been accessed, providers should click on the link entitled, “Web Account Registration,” which is on the left side of the web portal homepage and complete the appropriate fields to become a registered web portal user.

Once a provider has become a registered user of the web portal, the provider should simply access the web portal at <http://msmedicaid.acs-inc.com>, log into the secure portion of the web portal by clicking on the link entitled, “Log In,” and click on the “Print Images” tab. Print images of remittance advices will be listed here and will be available for downloading or printing for 60 days.

The Division of Medicaid and ACS State Healthcare would like for this to be a seamless transition for you. Should you have questions regarding the elimination of the paper remittance advice and available options, please contact EDI Support at 1-800-884-322.”

Providers submitting electronic claims through Electronic Dental Services should go to the Envision Web Portal at <http://msmediciad.acs-inc.com> to receive a print image of their RA or they may go to <http://mississippimedicaid.acs-inc.com> to obtain and 835 remit file.



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**PROVIDER ENROLLMENT FORM**

Print/Type the following:

Insurance Carrier: **Mississippi Medicaid – payer ID CKMS1**

Provider/Organization Name: \_\_\_\_\_

Tax Identification or Social Security Number: \_\_\_\_\_  
*(Number that will be used to submit electronic claims)*

Software Vendor: \_\_\_\_\_

Group Number: \_\_\_\_\_  
*(if applicable)*

Group NPI Number: \_\_\_\_\_  
*(if applicable)*

Name	Number	Rendering	NPI
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Date: \_\_\_\_\_



# EDI Provider Agreement and Enrollment Form

Please return to:  
Mississippi Medicaid Program  
Provider Enrollment  
P.O. Box 23078  
Jackson, Mississippi 39225



Please complete the following Mississippi Medicaid Provider EDI Enrollment Packet. The package consists of the ACS EDI Provider Enrollment Form, Mississippi EDI Provider Agreement and the ACS EDI Gateway Inc., Trading Partner Agreement. Once the package has been completed and signed please return it to the address above for processing. If you have any questions about the ACS EDI Provider Enrollment Form or EDI Trading Partner Agreement, contact the EDI Support Unit at 1.866.225.2502, Monday-Friday 7AM-5PM CST.

Please print or type. Complete all areas of Agreement and Enrollment form, unless otherwise indicated.

## EDI PROVIDER ENROLLMENT FORM

### Section 1 Application Type- Please select all that apply

- New Submitter (I would like to become a trading partner with ACS EDI to submit my claims such as 837.)
- New Retriever (I would like to become a trading partner with ACS EDI to retrieve my responses such as 835.)
- Change/Correction (I am a current trading partner with ACS EDI, I would like to update my current trading partner profile.)
- Billing Agent/Clearinghouse Authorization (I am a provider who will allow a billing agent/clearinghouse to submit and/or retrieve transactions on my behalf.)

### Section 2 Provider Information

*Provider/Business Name*

*Street Address*

*City, State, Zip Code*

<i>Telephone</i>	<i>Fax</i>
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*Pay-to Provider Number*

*EIN (Required if your pay-to number is registered as a group provider number with Mississippi Medicaid.)*

-

*Email Address*

### Section 3 Submitter/Trading Partner ID Number

If you are currently submitting electronic transactions directly to <b>ACS EDI Gateway, Inc.</b> , please indicate your ACS EDI Gateway Submitter/Trading Partner ID. (This section is required if you have chosen application type "change/correction" in section 1.)	<table border="1" style="display: inline-table;"> <tr> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px; text-align: center;">8</td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px; text-align: center;">7</td> <td style="width: 20px; height: 20px; text-align: center;">9</td> </tr> </table>	0	8	0	0	7	9
0	8	0	0	7	9		

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## Section 4 Individual Contact Information- Please indicate contact if different from Provider Information in Section 2 (Attach additional sheets if necessary)

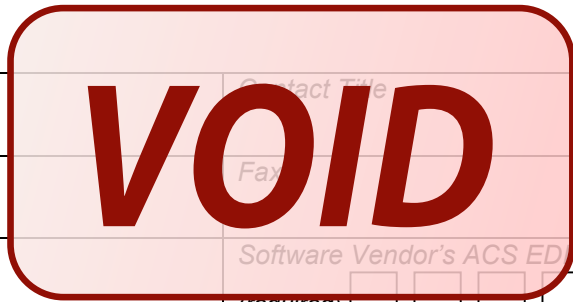
Contact Name	Contact Title
Street Address	
City, State, Zip Code	
Telephone	Fax
Email address	

## Section 5 Submission Method- Please indicate how you plan to submit your electronic transactions to Medicaid.

<input type="checkbox"/>	Vendor Software (If you select this option then you are required to complete sections 6 and 11.)
<input type="checkbox"/>	WINASAP2003 (If you select this option then you are required to complete section 10)
<input type="checkbox"/>	Web Portal (If you select this option then you are required to complete section 12.)
<input type="checkbox"/>	I plan to develop my own software (If you select this option then you are required to complete sections 7 and 11.)
<input type="checkbox"/>	I plan to use a Billing Agent/Clearinghouse (If you select this option then you are required to complete sections 8 and 11.)

## Section 6 Software Vendor Information- If you have indicated that you plan to use the services of a Software Vendor to submit your transactions electronically to ACS Edi Gateway, please provide the following information regarding your agent. Your Software Vendor is required to enroll and receive their own unique trading partner ID to test with ACS Edi Gateway. Please indicate your Software Vendor's ACS Edi Gateway trading partner ID. Please contact your Software Vendor for this required information.

Software Vendor Company Name	
Contact Name	Contact Title
Telephone	Fax
Email Address	Software Vendor's ACS EDI Gateway Trading Partner ID (required) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>



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**Section 7 I plan to develop my own software-** If you plan to develop your own software, you must test your software with ACS EDI Gateway. Please provide the following information.

<i>Software Name</i>	<i>Software Version</i>	<i>Protocol</i>
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**Section 8 Billing Agent/Clearinghouse Information-** If you have indicated that you plan to allow a Billing Agent/Clearinghouse to submit and/or retrieve transactions electronically with ACS EDI Gateway on your behalf, please provide the following information regarding your agent. Your Billing Agent/Clearinghouse is required to enroll and receive their own unique trading partner ID to test and transmit with ACS Edi Gateway. Please indicate your agent's ACS Edi Gateway trading partner ID. Please contact your agent for the required information.

<i>Billing Agent/Clearinghouse Company Name</i> Claims Processing Service, Inc. dba Emdeon Dental							
<i>Contact Name</i> Dawn L Vaughan	<i>Contact Title</i> Dental Vendor / Payer Liaison						
<i>Telephone</i> 888-255-7293	<i>Fax</i> 860-289-0055						
<i>Email Address</i> bdldn-operations@emdeon.com	<i>Billing Agent/Clearinghouse ACS EDI Gateway Trading Partner ID (required)</i> <table style="display: inline-table; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; text-align: center;">8</td> <td style="border: 1px solid black; width: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; text-align: center;">7</td> <td style="border: 1px solid black; width: 20px; text-align: center;">9</td> </tr> </table>	0	8	0	0	7	9
0	8	0	0	7	9		

**Section 9 Delimiter Information-** If you are submitting X12N transactions, please provide the following. (If nothing is entered the default delimiter will be used). (Note: Providers may need to contact their third-party vendor for this information.)

<i>Element Delimiter to be used:</i> <i>Default Delimiter (asterisk)</i> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin: 5px auto;">*</div>	<i>Segment Delimiter to be used:</i> <i>Default Delimiter (tilde)</i> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin: 5px auto;">~</div>	<i>Sub-Element Delimiter to be used:</i> <i>Default Delimiter (colon)</i> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin: 5px auto;">:</div>	
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**Section 10 Transactions - WINASAP2003**

Request for Software

I will download the WINASAP2003 Software (<http://msmedicaid.acs-inc.com>)

Please mail me a CD-ROM of the software

X12N 837P (Professional Claim)	<input type="checkbox"/>
X12N 837D (Dental Claim)	<input type="checkbox"/>



## EDI Provider Agreement and Enrollment Form



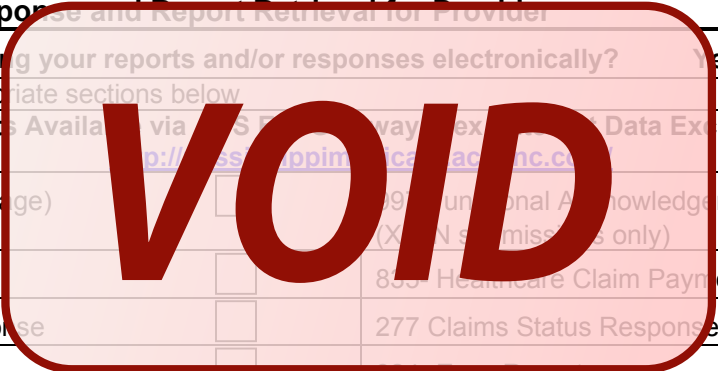
Please return to:  
**Mississippi Medicaid Program**  
 Provider Enrollment  
 P.O. Box 23078  
 Jackson, Mississippi 39225



<b>Section 11 Transactions - Other than WINASAP2003</b>			
X12N 837P (Professional Claim)	<input type="checkbox"/>	X12N 270 (Eligibility Inquiry)	<input type="checkbox"/>
X12N 837D (Dental Claim)	<input type="checkbox"/>	X12N 276 (Claim Status Inquiry)	<input type="checkbox"/>
X12N 837I (Institutional Claim)	<input type="checkbox"/>	X12N 278 (Prior Authorization)	<input type="checkbox"/>

<b>Section 12 Web Transactions</b>			
X12N 837P (Professional Claim-batch only))	<input type="checkbox"/>	X12N 270 (Eligibility Inquiry- batch only)	<input type="checkbox"/>
X12N 837D (Dental Claim-batch only)	<input type="checkbox"/>	X12N 276 (Claim Status Inquiry- batch only)	<input type="checkbox"/>
X12N 837I (Institutional Claim- batch only)	<input type="checkbox"/>	X12N 278 (Prior Authorization- batch only)	<input type="checkbox"/>

<b>Section 13 Electronic Response and Report Retrieval for Provider</b>			
<b>Are you interested in retrieving your reports and/or responses electronically?</b>			Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please fill out the appropriate sections below			
<b>Reports Available via ACS EDI Gateway Exchange</b>			
Remittance Advice (as print image)	<input type="checkbox"/>	997 Functional Acknowledgement (X12N submissions only)	<input type="checkbox"/>
271- Eligibility Response	<input type="checkbox"/>	835- Healthcare Claim Payment Advice	<input type="checkbox"/>
278- Prior Authorization Response	<input type="checkbox"/>	277 Claims Status Response	<input type="checkbox"/>
820- Premium Payment	<input type="checkbox"/>	824- Error Report	<input type="checkbox"/>



<b>Section 14 Electronic Response and Report Retrieval for Billing Agent or Clearinghouse</b>									
<b>Do you authorize your Billing Agent/Clearinghouse to retrieve your response and/or reports electronically on your behalf?</b>									
Yes <input type="checkbox"/> No <input type="checkbox"/>									
If yes, please fill out the appropriate sections below									
<i>Billing Agent/Clearinghouse Company Name (required)</i>	<i>Billing Agent/Clearinghouse ACS EDI Gateway Trading Partner ID (required)</i>								
Claims Processing Service, Inc. dba Emdeon Dental	<table style="border: 1px solid black; display: inline-table; text-align: center;"> <tr> <td style="width: 20px;">0</td> <td style="width: 20px;">8</td> <td style="width: 20px;">0</td> <td style="width: 20px;">0</td> <td style="width: 20px;">7</td> <td style="width: 20px;">9</td> </tr> </table>			0	8	0	0	7	9
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271- Eligibility Response	<input type="checkbox"/>	835- Healthcare Claim Payment Advice	<input type="checkbox"/>						
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820- Premium Payment	<input type="checkbox"/>	824- Error Report	<input type="checkbox"/>						

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**Section 15 Web Portal-** (Note: You will not be able to receive an X12 response unless you submitted an X12 transaction)

I will retrieve my reports from the web. (Note: Only available if transactions were submitted through the web portal- see Section 12)

**Reports Available via Web Portal**

<http://msmedicaid.acs-inc.com>

271- Eligibility Response	<input type="checkbox"/>	997 Functional Acknowledgement (X12N submissions only)	<input type="checkbox"/>
278- Prior Authorization Response	<input type="checkbox"/>	835- Healthcare Claim Payment Advice	<input type="checkbox"/>
820- Premium Payment	<input type="checkbox"/>	277 Claims Status Response	<input type="checkbox"/>
824- Error Report	<input type="checkbox"/>		



# EDI Provider Agreement and Enrollment Form



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Jackson, Mississippi 39225



The following constitutes an Electronic Data Interchange Agreement (“EDI Agreement”) between the Health Care Provider listed in Section II (“Provider”) and the Mississippi Division of Medicaid (“DOM”) or its designated Fiscal Agent. This EDI Agreement defines the requirements for Electronic Data Interchange between the Provider and the DOM or its designated Fiscal Agent. Any references in this EDI Agreement to the submission of electronic transactions, refers to electronically submitted transactions as chosen by the Provider.

## Section I—Terms of Agreement

The Provider agrees to abide by the requirements for Administrative Simplification as defined in the provisions of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) based on the compliance date of the final rules or a date mutually agreed upon between the Provider and the DOM or its designated Fiscal Agent.

The Provider agrees to abide by the requirements for EDI submissions and submitters as published in the appropriate DOM Electronic Transactions Submission Manual.

The Provider agrees to send and receive data in a manner that protects the integrity and confidentiality of the transmitted information according to the relevant provisions of state and federal laws and regulations.

The Provider agrees that if a Billing Agency or Clearinghouse is used for the submission of electronic transactions, the Billing Agency or Clearinghouse identified in Section III must have a Trading Partner Service Agreement on file with the DOM or its designated Fiscal Agent.

If using a Billing Agency or Clearinghouse, the Provider agrees to report information accurately and completely to the Billing Agency or Clearinghouse as required in the Appropriate DOM Electronic Transactions Submission Manual and agrees to be completely responsible for the electronic transactions generated from the information submitted to the DOM or its Fiscal Agent by the Billing Agency or Clearinghouse.

If using a Billing Agency or Clearinghouse, the Provider agrees to not use any Billing Agency or Clearinghouse except the one listed in Section III of this agreement until this EDI Agreement has been terminated in writing to the DOM or its designated Fiscal Agent.

If using an EDI software vendor for submission of electronic transactions, the Provider agrees to insure that all data meets the requirements for EDI submissions and submitters as published in the appropriate DOM Electronic Transactions Submission Manual.

If any information supplied in this EDI Agreement changes at any time during the Provider’s enrollment in the Mississippi Medicaid program, the Provider agrees to notify the DOM or its designated Fiscal Agent immediately in writing. Failure to do so may invalidate this EDI Agreement.

Whenever necessary, this EDI Agreement may be amended by mutual consent of the DOM and the Provider to meet federal or other operational requirements.

The Provider agrees that the EDI Submitter ID is confidential and is not transferable or assignable. This EDI Agreement is not transferable or assignable and may be terminated on thirty (30) days written notice by either party.

This EDI Agreement is automatically terminated in the event the Provider’s license is revoked by the Appropriate Board, the Provider is disqualified through a federal administrative action, or as set forth in Miss. Code Ann. Section 43-13-121(l) (1972, as amended)

## Authorization

I certify that all statements made herein are true and complete to the best of my knowledge

Authorized Signature

Date

SIGN HERE



# ACS EDI Gateway, Inc. Provider Agreement

Please return to:  
Mississippi Medicaid Program  
Provider Enrollment  
P.O. Box 23078  
Jackson, Mississippi 39225



## ACS EDI GATEWAY TRADING PARTNER AGREEMENT

**THIS TRADING PARTNER AGREEMENT** ("Agreement") is by and between **SUBMITTER** ("Submitter") and **ACS EDI GATEWAY, INC.** ("Trading Partner"), collectively "the Parties."

**Whereas**, Submitter desires to transmit Transactions to Trading Partner for the purpose of submitting data to the Mississippi Division of Medicaid;

**Whereas**, Trading Partner desires to receive such Transactions for this purpose; and

**Whereas**, Submitter is subject to the Transaction and Code Set Regulations with respect to the transmission of such Transactions.

Now, therefore, the Parties agree as follows:

### 1. Definitions

Trading Partner means ACS EDI Gateway, Inc.

Submitter means the party identified as "Submitter" on the signature line of this Agreement who is a Health Care Provider as defined in 45 CFR 164.103.

Standard is defined in 45 CFR 160.103.

Transaction is defined in 45 CFR 160.103.

Transactions and Code Set Regulations means those regulations governing the transmission of certain health claims transactions as published by DHHS under HIPAA.

### 2. Obligations of the Parties Effective Upon Execution of this Agreement by Submitter

A. The Parties agree, in regard to any electronic Transactions between them:

- (1) They will exchange data electronically using only those Transaction types as selected by Submitter on the ACS EDI Gateway Trading Partner Enrollment Form (TPEF).
- (2) They will exchange data electronically using only those formats (versions) as specified on the TPEF.
- (3) They will not change any definition, data condition, or use of a data element or segment in a Standard Transaction they exchange electronically.
- (4) They will not add any data elements or segments to the Maximum Defined Data Set.
- (5) They will not use any code or data elements that are not in or are marked as "Not Used" in a Standard's implementation specification.
- (6) They will not change the meaning or intent of a Standard's implementation specification.





***SIGN HERE***